STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155430	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT ROCHESTER	340 E 18TH ST ROCHESTER, IN46975

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 7, 8, 9, 10, 2011. Facility number: 000326 Provider number: 155430 AIM number: 100290770 Survey Team: Tim Long, RN, TC Julie Wagoner, RN Angie Strass, RN Census bed type: SNF/NF: 32 Total: 32 Census payor type: Medicare: 4 Medicaid: 21 Other: 7 Sample: 10 These deficiencies also reflect state findings in accordance with 410 IAC 16.2 Quality review completed 3-15-11 Cathy Emswiller RN	F0000	March 25, 2011Kim RhodesDivision of Long term CareIndiana State Department of Health2 North Meridian Street, Section 4-BIndianapolis, Indiana 46204-3006RE: Hickory Creek at Rochester Provider No: 15-5430 Annual Recertification SurveyDear Ms. Rhodes:Attached for your review and anticipated approval, you will find the completed form CMS-2567L Statement of Deficiencies and Plan of Correction for recent Annual Recertification Survey conducted March 7, 2011 through March 10, 2011, at Hickory Creeka t Rochester, Rochester, Indiana.Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective March 31, 2011.Should you have any questions regarding the attached Plan of Correction/Allegation of Compliance, then please do not hesitate to contact me.Sincerely,Laura AlbrightAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0225 SS=A	Based on record review and interview, the facility failed to report an alleged incident of resident abuse in a timely manner for 1 of 32 residents (resident #35). Findings include: On 3/10/11 at 9:30 A.M. a review of a resident abuse investigation report from 11/10/10 indicated at 3:30 P.M. during a care plan meeting with resident #30 an allegation was made by the resident's family of how her roommate (#35) was handled by a third shift CNA. Immediately following the Care Plan meeting the Social Service Director reported the concern to the Administrator and the investigation process was started as outlined in the facility protocol. The third shift CNA was not scheduled for work on 11/10/11 or 11/11/11 and was notified of suspension pending investigation on 11/11/11 by telephone and removed from the schedule until the investigation was completed. The investigation was completed with interviews with both residents involved (#30, #35), interviews with all alert and oriented residents and staff interviewed and statements written. A mandatory	F0225	What corrective action will be done by the facility? It is the policy of this facility to report alleged incidents of resident abuse in a timely manner. All staff will be in-serviced on proper procedures of reportable incidents and timeliness of reporting incidents to Administrator, Director of Nursing, and the proper state agency by March 31, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were affected by this deficient practice. The Administrator or designee will report all incidents, accidents, and other unusual occurrences to the proper state agencies within 24 hours with an initial report and a final report within five days. What measures will be put into place to ensure this practice does not recur? A log will be created by the Administrator for all reportable incidents to track timeliness of reporting an incident and ensuring all proper investigation procedures are followed. All incidents occurring in the facility will be reported to the Administrator or designee to determine if it is a reportable incident to ensure timeliness of reporting to the proper state agency. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into	03/31/2011

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	inservice was conducted with all staff on policies and procedures related to abuse. On 11/17/11 after the investigation was completed, the 3rd shift CNA was terminated. An interview with the facility Nurse Consultant on 3/15/11 at 2:35 P.M. indicated the initial report was not sent to the Indiana State Department of Health within 24 hours. The Nurse Consultant indicated the follow-up report was sent to the Indiana State Department of Health on 11/12/11. Review of the facility's policy and procedure titled, "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property." included: "residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion."; "Physical abuse: includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment."; "Training: Employees, whether direct care, contract staff, ancillary departments, volunteers, or consultants, receive instruction/training on neglect, abuse, misappropriation of resident belongings,		place? The Administrator will bring the reportable incident log to the monthly QA meeting for review and recommendations for process improvement. Any recommendations made by the committee will be followed up by the appropriate interdisciplinary team member, and the results of those recommendations will be reported back to the QA Committee at its next scheduled meeting. Date of Compliance: 3-31-11	

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	and the reporting requirements during orientation and periodically during ongoing inservice education."; "Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of witness/identification). The facility has a designated employee/supervisor on each shift/tour of duty responsible for the initial reporting and investigation of allegations of mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion, injuries of unknown or unwitnessed etiology or significant injuries. This designated employee with communicate all investigation information to the administrator, who will determine further action. All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process." 3.1-28(c)			

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F0279 SS=D	Based on record review and interviews, the facility failed to develop a care plan regarding pacemaker care for 1 of 10 residents reviewed for care plans in a sample of 10. (Resident #8) Finding includes: The clinical record for Resident #8 was reviewed on 03/09/11 at 1:35 P.M. Resident #8 was admitted to the facility on 03/22/10 with diagnosis, including but not limited to history of seizures, traumatic brain injury due to a cerebral embolism, and status post pacemaker insertion. The most recent health care plans for Resident #8, dated as current as of January 4, 2011 indicated there was no plan to address the resident's pacemaker. On 03/10/11, a health care plan was presented, initiated on 03/09/11 for the use of the pacemaker. Interview on 03/10/11 at 10:45 A.M. with the Minimum Data Set (MDS) nurse #5, indicated she was not aware of the resident's pacemaker until 03/09/11. She indicated she was going to check with the resident's primary care physician regarding who was the resident's cardiologist .	F0279	What corrective action will be done? It is the policy of this facility to develop comprehensive care plans for each resident that includes measureable objectives and timetables to meet a resident' s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A care plan for resident #8 was written on March 9, 2011, regarding pacemaker care with measureable objectives and goals. The doctor and family were notified and an appointment was set up with the cardiologist to determine necessary pacemaker checks. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? An initial audit was performed by the MDS Coordinator for all residents residing in facility that have pacemakers to ensure a care plan is in place with measureable objectives and goals. The MDS Coordinator or Designee will check all new admissions upon admit to see if resident has a pacemaker and if so a care plan will be initiated. What measures will be put into place to ensure this practice does not recur? Residents with pacemakers will have information put on the treatment sheet to indicate practices of care and checks. A care plan will be initiated upon	03/31/2011

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	A note from a heart center was located in the resident's record, dated 01/05/11, reminding the resident of the need for a telephone check of her pacemaker, scheduled for April 11, 2011. Interview with LPN #6, on 03/10/10 at 1:35 P.M. indicated she had checked with the resident's primary care physician and the resident should have received telephone pacemaker checks every three months routinely but there was no need for an appointment with the cardiologist that frequently unless there were problems. Interview with the Corporate Nurse Consultant, RN #7, on 03/10/10 at 2:50 P.M. indicated there was no documentation the resident had received her routine pacemaker checks and no previous care plan documentation related to the resident's pacemaker had been located. 3.1-35(a)		admission and updated as necessary to ensure proper objectives and goals will be met. A care plan audit will be performed one time per week for four weeks, then one time per month for six months on all residents with pacemakers and issues and concerns will be brought to the monthly QA committee for proper follow up. Staff will be in-serviced on March 29, 2011 regarding care plans and ensuring proper care for resident needs are met. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? A care plan audit will be performed one time per week for four weeks, then one time per month for six months on all residents with pacemakers and issues and concerns will be brought to the monthly QA committee for proper follow up. Date of Compliance: March 31, 2011	

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F0309 SS=D	Based on record review, observation and interview the facility failed to ensure 1 resident (#6) of 6 residents reviewed, was positioned in bed according to physical therapy recommendations. Finding includes: Review of the clinical record for resident (#6) on 3/9/11 at 10:30 a.m. indicated the resident was admitted to the facility on 4/24/08 with diagnoses including but not limited to Vascular Dementia, Hypertension and Osteoporosis. Review of a quarterly minimum data set dated 2/24/11 indicated the resident required extensive assistance for activities of daily living. Review of a physical therapy note dated 1/25/11 indicated the resident was to be in bed on her back or right side with a contour pillow between her legs and her left arm on a pillow as the resident had lymphedema of her left arm/hand. Observation of the resident on 3/9/11 at 2:10 p.m. indicated the resident was in bed on her left side with a pillow under her left leg and a pillow under her left arm. Observation of the resident on 3/10/11 at	F0309	What corrective action will done? It is the policy of this facility that each resident receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. Resident #6 per minimum data set dated February 24, 2011 requires extensive assist for activities of daily living and per therapy recommendations resident is to be positioned on back or right side with contour pillow between legs and left arm to be elevated on pillow. Assignment sheets were updated with information to educate staff on resident needs. A care plan will be initiated to show objective goals and needs of resident. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No other residents were affected by this practice. DON or designee will do daily rounds to ensure resident is placed in proper position with proper equipment. DON or designee will update assignment sheet with accurate information regarding resident needs and educate staff of	03/31/2011

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	1:45 p.m. indicated the resident was in bed on her left side with a contour pillow between her legs. At 1:55 p.m. interview with certified nursing assistant #1 indicated the resident was to be on her right side. Further interview indicated she did not know who had put the resident in bed, and when queried how staff would know how to position the resident she indicated it should be on the cna (certified nursing assistant) assignment sheet. Review of the assignment sheet indicated there were no instructions related to how the resident was to be placed in bed. 3.1-37(a)		necessary changes. A turn schedule will be created for staff to be aware of resident needs. Staff will be in serviced on March 29, 2011 regarding assignment sheets and notifying of changes to residents needs. What measures will be put into place to ensure this practice does not recur? DON or designee will do daily rounds to ensure resident is placed in proper position with proper equipment. Any resident that is to have proper position or assistance with bed mobility will be placed on the assignment sheet and a care plan initiated. A turn schedule will be created for staff to be aware of each resident's needs. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? DON or designee will do daily rounds to ensure residents that need assistance with bed mobility will be performed for one month then weekly for one month, then periodically ongoing. Issues and concerns will be forwarded to the QA committee for proper follow up and disciplinary action as necessary. Compliance Date: March 31, 2011	

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F0371 SS=A	Based on observation, interview and review of facility documents, the facility failed to ensure 1 of 2 freezers maintained a temperature of zero degrees or below. Finding includes: Observation of the kitchen on 3/7/11 at 10:10 a.m. indicated a freezer had a temperature of 10 degrees. Interview with the dietary manager indicate the freezer never gets below 9 or 10 degrees. On 3/11/11 at 10:40 a.m. observation of the freezer indicated a temperature of 10 degrees. Review of the freezer temperature logs for December 2010 through March 7, 2011 indicated the temperature of the freezer was never below 10 degrees except for February 28, 2011 at which time the temperature was recorded at 8 degrees. 3.1-21(i)(1)	F0371	What corrective action will be done by the facility? It is the policy of this facility to procure, store, prepare, and serve food in a sanitary manner. A capital requisition was processed and approved on March 10, 2011 for the purchase of a new freezer. A new freezer was ordered on March 10, 2011 and received and installed on March 15, 2011. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this deficient practice. The dietary manager will continue to monitor and document freezer temperatures to ensure they are within proper range. Any temperatures that are documented out of range will be reported to the maintenance director for further attention. What measures will be put into place to ensure this practice does not recur? Continued monitoring of freezer temperatures will be documented on a daily basis. If the temperature is not within proper range the maintenance director will be notified	03/31/2011

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			for further attention. Dietary Staff will be in-serviced about recording temperatures by March 31, 2011 and reporting unusual readings to the maintenance director. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will b e put into place? The dietary manager will bring the temperature logs to the monthly QA meeting for review and recommendations for process improvement. Any recommendations made by the committee will be followed up by the appropriate interdisciplinary team member, and the results of those recommendations will be reported back to the QA committee at its next scheduled meeting. Date of Compliance: 3-31-11	

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F0465 SS=B	Based on observation, record review, and interviews, the facility failed to maintain the closet area in 12 of 18 resident rooms. (Room #2, 4, 5, 6, 7, 8, 11, 12, 13, 14, 16, and 17) Findings include: During the Environmental tour of the facility, conducted on 03/09/11 between 10:00 A.M. - 11:15 A.M., accompanied by the Maintenance Supervisor and the Administrator, and on a subsequent room to room tour of the building, conducted on 03/10/11 between 12:45 P.M. - 1:15 P.M., the following was noted: Room 2, which housed two residents, had missing woodwork with exposed nails and splintered wood above the newly purchased wardrobes. Interview with the Maintenance Supervisor indicated the previous build in wardrobes/closets had been removed and new furniture purchased. The new wardrobes were smaller than the previous closet opening so there was also an approximately 4 inch gap between the top of the new wardrobes and the exiting wall. The Maintenance Supervisor indicated the rooms were to completely remodeled with new dry wall, paint, and flooring. Interview with the Administrator indicated there was no really a proposed, definite timeline for the	F0465	What corrective action will be done by the facility? It is the intent of this facility to ensure that all residents, public, and staff be provided a safe, functional, sanitary, and comfortable environment. A plan for room renovations was created on March 10, 2011 and presented to surveyors outlining that rooms will be repaired and residents will be provided a safe, functional, sanitary, and comfortable environment with in three to five months. Room #2, 4, 5, 6, 7, 8, 11, 12, 13, 14, 16, and 17 will have the necessary repairs as listed. Tile on floor where wardrobe is placed in will be replaced with new tile as necessary. The wood trim around the wardrobes will be replaced as needed. The gap between the wardrobe and the top of the wood trim will be finished. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by the deficient practice. All exposed nails and wood splinters will be removed. The maintenance director or designee will monitor resident rooms on a monthly basis per the maintenance resident room check list to ensure that no exposed nails or wood splinters are present during the renovation	05/31/2011

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	remodeling plans, but the funds had been secured to complete the project. Room 4, which housed 2 residents, had missing and/or broken floor tiles exposed about an inch in front of the new wardrobe units. There was also a 4 - 5 inch gap between the top of the wardrobe units and the existing wall. Room 5, which housed 2 residents, had missing floor tiles visible between the existing wall and to the sides of the new wardrobe units on each side. There was also a 4 - 5 inch gap between the top of the wardrobe units and the existing wall. Room 6, which housed 2 residents, had 6 - 12 inch gaps between each side and in between the two new wardrobe unit. There were two ill fitting pieces of drywall wedged on the outsides of each wardrobe. There was cracked and/or missing floor tile visible between the wardrobe units. There was missing woodwork above the units with exposed dry wall and nails and cement block. There was a rolled up air mattress being stored in between the storage units on the unfinished floor. One of the residents in the room indicated it had been like that every since she had lived in the room and she hoped they were going to fix it soon.		process. What measures will be put into place to ensure this practice does not recur? The maintenance director or designee will monitor resident rooms on a monthly basis per the maintenance resident room check list to ensure that no exposed nails or wood splinters are present during the renovation process. Any issues or concerns found will be fixed immediately. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The maintenance director or designee will continue to monitor resident rooms on a monthly basis per the resident room check list and report to the QA committee any issues or concerns for further follow up as necessary.Compliance Date: May 31, 2011	

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Room 7, which housed 3 residents, had an approximately 8 inch gap between two of the three wardrobe units. There was cracked and/or missing floor tile exposed in the gaps. There was also a 4 - 5 inch gap between the tops of the wardrobe units and the existing wall. There were dusty, black pipes exposed, and splintered wood noted. There was also a piece of cove base missing from the corner between the wardrobes and the sink.

Room 8, which housed 2 residents had an approximately 2 inch section of missing floor tile in front of 1 of the 2 wardrobe units. There was also a 4 inch gap above 1 of the wardrobe units and the existing wall. The second wardrobe unit did not fit into the existing gap where the previous closets had been, so it was sitting cockeyed and jutted out into the room.

Room 11, which housed 3 residents, had three wardrobe units sitting side by side. There was a 2 inch gap on each outside wardrobe unit between the unit and the existing wall. There was cracked and/or missing floor tile exposed in the gaps.

Room 12, which housed 2 residents, had two wardrobes with a 6 inch gap in between the two wardrobes. There was

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HICKORY CREEK AT ROCHESTER	340 E 18TH ST ROCHESTER, IN46975

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	missing and/or cracked floor tiles exposed in the gap. The residents had utilized the 6 inch space for storage of personal items. There was also a 4 inch gap above the wardrobe units between the units and the existing wall. Room 13, which housed 2 residents, had two wardrobe units sitting side by side with 1 1/2 inch and 2 inch gaps between the outside of the units and the wall opening. There was cracked and/or missing floor tiles exposed on each side in the gaps. Room 14, which housed 2 residents, had a 4 inch gap between the two wardrobe units. The exposed floor between the units had broken and/or missing tile. Room 16, which housed 2 residents, had a 6 inch gap between the two wardrobe units. The floor tile in between the wardrobe units was cracked. Room 17, which housed 2 residents, had a 5 inch gap between the two wardrobe units. There was no floor tile present between the units. There was also a 4 - 5 inch gap above the wardrobe units between the units and the existing wall opening.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155430	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Review of a facility plan for room renovations, provided by the administrator on 03/10/11 at 11:35 A.M. indicated the old closet units had been removed and new furniture placed in the room in August 2010. The plan indicated the wood trim around the new wardrobes, the gaps between the wall openings and the tops and side of the new wardrobes, and the floor tile underneath the wardrobes would all be replaced in 3 - 5 months. Interview with the Corporate Administrator, on 03/10/11 at 10:30 A.M. indicated the Maintenance Supervisor and other maintenance staff from other buildings would be completing the remodeling. He indicated the total room remodeling, including changing the ceiling, new drywall, and finishing the closet area would take a year to complete. 3.1-19(f)			